



Wyoming
Department
of Health

Nursing Home

Nursing Home overview and billing

How to Contact your Field Representative

- The Provider Outreach email address is the correct email for the Field Representatives
 - wyprovideroutreach@cns-inc.com
 - Attestations are also sent to this email address
- Claim Denials, Eligibility, and Prior Authorization questions can be completed through the Call Center
 - 1-888-996-6223

Course Content

- Prior Authorization Look up
- Member Eligibility
- Attestation and LT101
- PASRR Information and PASRR I submission
- Value Codes
- Billing Examples
- Top 5 common denials and how to resolve
- How to bill a straight claim
- Error Codes
- Adjustments

Prior Authorization

Searching and Seeing a Prior Authorization

Prior Authorization- Sign on



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ACS TEST PROVIDER-NOT VALID 900000300

Prior Authorization Access

Select Favorite

Go

- Select the applicable domain from the Domain drop-down list
- Select Prior Authorization from the Profile drop-down list
- Select Go

Prior Authorization- PA Inquire

Department of Health

My Inbox ▾ PA ▾

PA REQUEST LIST

PA Request List ★

PA INQUIRE

PA Inquire ★

System Notification

System Maintenance Planned: A planned maintenance window for system maintenance access to the Wyoming Medicaid system and its functions will be unavailable. This includes maintenance will also affect 270//271s, EDI gateways, and Real-Time Services. We appreciate your understanding during these maintenance activities occur.

Provider Portal > PA Inquire

Close Submit

PA Inquire

Tracking No.: *

When the PA tracking number is available:

- Select PA at the top of the screen
- PA Inquire
- Enter tracking number
- Select Submit

PA Inquire- Search Results

Close

PA Utilization

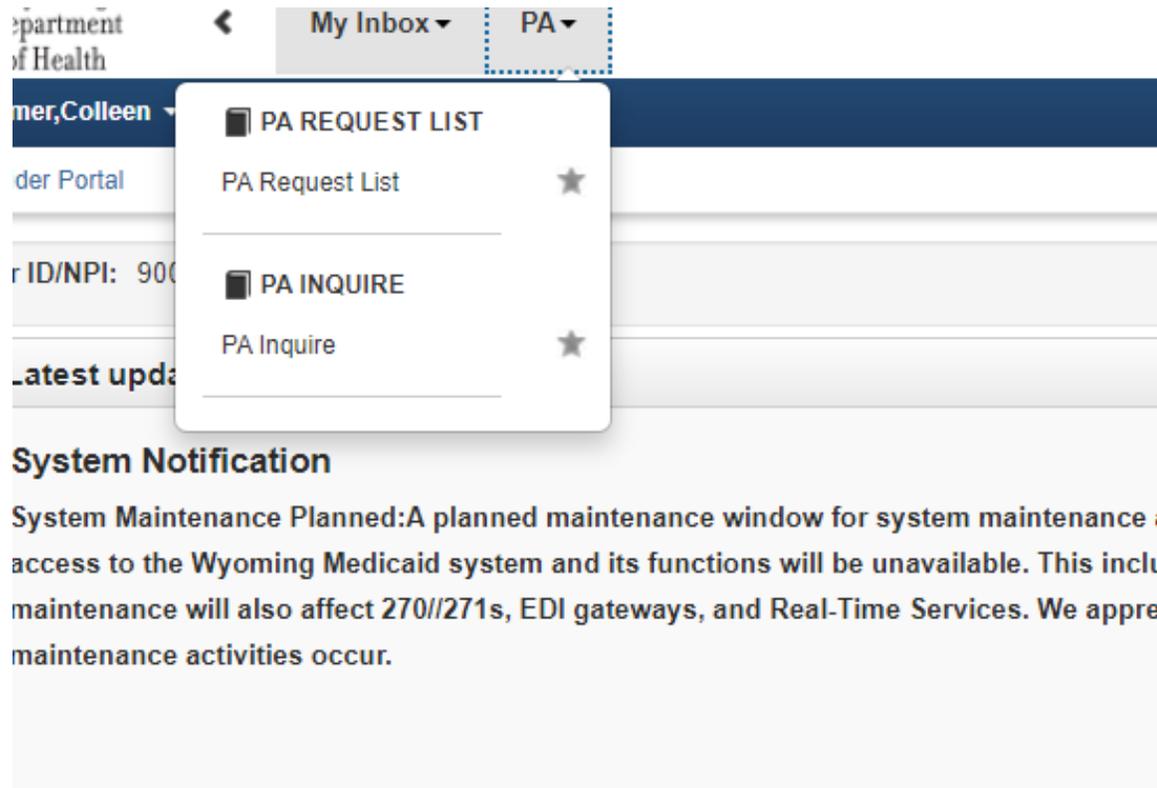
Tracking No:	100010339	Authorization Status:	In Process
Beneficiary ID:	0000224651	Beneficiary Name:	Caine, Marabel
Service:	Respite Care	Organization:	CNSI_BO
Request Date:	02/16/2023	Last Updated Date:	02/16/2023
Service Start Date:	01/01/2023	Service End Date:	01/13/2023
Requestor NPI:	1194105684	Requestor Name:	Xantiwai
Requestor ID:	198803292	Source of Request:	Phone/Verbal

PA Line Information

PA Line	Servicing Provider NPI	Servicing Provider ID	Servicing Provider Name	From Date	To Date	Code	Modifiers	Tooth Number	Approved Units	Utilized Units	Approved \$ per Unit	Apprvd Total Auth Amt	Total Utilized Amt	Status
> 01	1194105684	198803292	Xantiwai	01/01/2023	01/13/2023	0101			0	0	0.00			Requested

- The statistical information is displayed
- TCN's that have been billed to the prior authorization will displayed

Prior Authorization- PA Request List



If the PA Tracking number isn't available:

- Choose PA at the top of the screen
- Select PA Request List

Prior Authorization- PA Request List- Filters

The screenshot shows the top-left corner of the 'PA Request List' application. At the top, there are two buttons: 'Close' and 'Add New Rec'. Below them is a header bar with a grid icon and the text 'PA Request List'. A dropdown menu is open, showing a list of filter options. The 'Filter By' option is highlighted in blue. The list of filters includes: Assigned On, Assigned To, Beneficiary ID, Beneficiary Name, Days Left, Due Date, NPI/ID, Org, Procedure Code, Prvdr Name, Request Date, Source, Speciality Code, Srvc From Date, Status, and Tracking No.

- Filters are available to help narrow PA population
- After searching all the prior authorization associated to the group will populate.
- Select the correct prior authorization

The screenshot shows the search bar of the 'PA Request List' application. It features a header bar with a grid icon and the text 'PA Request List'. Below the header, there is a search bar with three input fields. The first field is labeled 'NPI/ID' and contains the value '1234657890'. The second field is labeled 'Beneficiary ID' and contains the value '0600123456'. The third field is labeled 'Procedure Code' and contains a '%' symbol. The search bar is separated into sections by 'And' labels.

Prior Authorization- PA Request List- Reading the PA

The screenshot displays a web-based form for a Prior Authorization (PA) request. The form is titled "PA Basic Info" and includes a sidebar with navigation options: PA Basic Info, Beneficiary Info, Provider Info, Diagnosis Info, Procedure Info, Additional Documents, and Acknowledge Submission. The main form area is divided into three sections: PA Basic Info, Beneficiary Info, and Provider Info. The PA Basic Info section contains fields for Request Received Date (02/16/2023), Certification Type (I-Initial), Request Category, Source of Request (PV-Phone/Verbal), Service Type (Respite Care), Service From Date (01/01/2023), Service To Date (01/13/2023), and Prev. Auth. Number. The Beneficiary Info section includes Beneficiary ID (0000224651), Beneficiary Name (Caine, Marabel), Gender (F-Female), and DOB (12/01/1925). The Provider Info section includes Requestor Information with fields for Requestor NPI (1194105684), Requestor ID (198803292), and Requestor Name (Xantawal). The form has "Save" and "Cancel" buttons at the bottom of each section.

Tracking Number: 100010339 Service From Date: 01/01/2023 Service To Date: 01/13/2023 Beneficiary ID: 0000224651

PA Basic Info

*Request Received Date: 02/16/2023 *Certification Type: I-Initial Request Category: *Source of Request: PV-Phone/Verbal Service Type: Respite Care *Service From Date: 01/01/2023 *Service To Date: 01/13/2023 Prev. Auth. Number: Save Cancel

Beneficiary Info

*Beneficiary ID: 0000224651 Beneficiary Name: Caine, Marabel *Gender: F-Female *DOB: 12/01/1925 Cancel Request Save Cancel

Provider Info

Requestor Information

Requestor NPI: 1194105684 Requestor ID: 198803292 Requestor Name: Xantawal

- Alternative view of the PA, with the same information as PA Inquire
- “PA Basic Info” allows quick navigation through the PA

Member Eligibility

Reading Eligibility and Member Primary Insurance

Member Eligibility- Nursing Home Plans

Benefit plans that can bill Nursing home claims:

- NH (Nursing Home)
- CCW (Community Choice Waiver)
- COAW (Comprehensive Adult Waiver plan)
- SUAW (Supports Adult Waiver)

Member Eligibility- Sign On



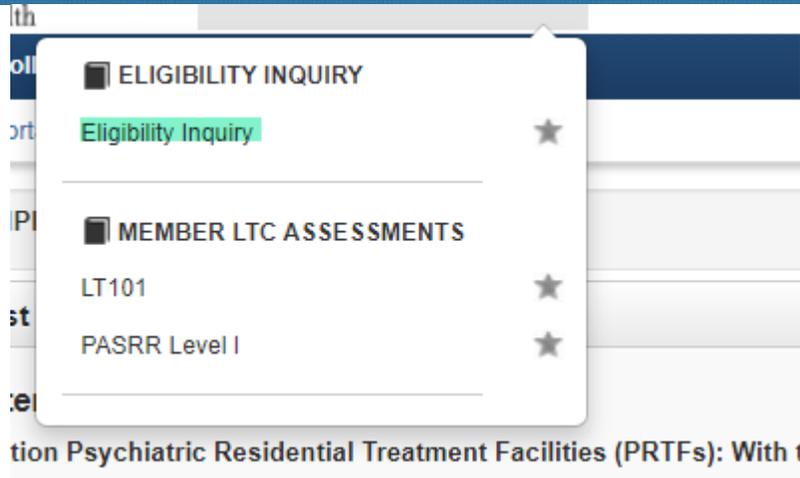
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ACS TEST PROVIDER-NOT VALID 900000300 *

Eligibility Inquiry *

Select Favorite Go

- Select “Eligibility Inquiry” for the domain
- Then once signed in:
 - Click Member
 - Click Eligibility Inquiry



ELIGIBILITY INQUIRY

Eligibility Inquiry ★

MEMBER LTC ASSESSMENTS

LT101 ★

PASRR Level I ★

tion Psychiatric Residential Treatment Facilities (PRTFs): With t

Member Eligibility- Search

To submit an Eligibility Inquiry on a specific Member, complete one of the following criteria sets and click 'Submit'.

- Member ID/Card Number or
- Last Name, First Name and Date Of Birth or
- Last Name, First Name and SSN or
- SSN and Date Of Birth
- Additional Search Options (Use if needed with one of the Search Options above to obtain a unique member match) :
 - Gender
 - Zip Code
 - Case Number
 - Diagnosis Code(s)
 - Procedure/Revenue Code

MEMBER ELIGIBILITY INQUIRY

Search By Service Type(s):

Servicing Provider NPI/Provider ID: *

Filter By:

Last Name:

Date of Birth:

Gender:

MA Case Number:

Inquiry Start Date: *

Diagnosis Code(s): 1: 2: 3: 4:

Procedure/Revenue Code:

SSN:

First Name:

Zip Code:

Inquiry End Date: *

- Enter the Member's ID
- Enter the date for inquiry
- Enter Diagnosis or Revenue codes as applicable
- Click Submit

Member Eligibility- Member File

Inquiry Date Range:	02/01/2023 - 02/01/2023	Commercial / Other:	N
Gender:	FEMALE		
Date Of Birth:	12/01/1925		
Case Number:		Lock-In Provider Restriction:	N
Case Phone:		Ext:	Indicators: N
Case Email:			
County Of Residence:	02-LARAMIE		
Citizenship:		Phone:	
Diagnosis Code 1:	Z3800	Diagnosis Code 1 Covered:	No
Diagnosis Code 2:		Diagnosis Code 2 Covered:	
Diagnosis Code 3:		Diagnosis Code 3 Covered:	
Diagnosis Code 4:		Diagnosis Code 4 Covered:	
Procedure/Revenue Code:	0100	Procedure/Revenue Code Covered:	Yes
			Non Covered Service Types

- Member specific information is displayed
- Hyper links are available for more specificity

Member Eligibility- TPL (Primary Insurance)

Commercial / Other: Y

Lock-In Provider Restriction: N

Indicators: N

Phone:

[Print Member Summary](#)
[Non Covered Service Types](#)

- Choose “Commercial/ Other” when the indicator is Yes
- This will populate the commercial insurance for the member

All Active Go Save Filters My Filters

PAYER NAME	PAYER ID	COVERAGE TYPE	B DATE LAST UPDATED	BEGIN DATE	END DATE
MEDICAREENROLLED IN PART A	33333333	AA	:02/23/2022	11/01/2011	12/31/2999
MEDICAREENROLLED IN PART B	44444444	BB	:02/23/2022	11/01/2011	12/31/2999
MEDICAREENROLLED IN MEDICARE PART D	66666666	DD	:02/25/2022	04/01/2022	12/31/2999

View Page: 1 Go Page Count SaveToXLS << First < Prev > Next >> Last

Member Eligibility- Code Information

Member ID: 0000224651 Name: CAINE, MARABEL

[Close](#)

Disclaimer: Eligibility shown does not guarantee payment of services.

Procedure/Revenue Code: 0100 Description: ALL INCLUSIVE RATE - ALL-INCLUSIVE ROOM AND BOARD PLUS ANCILLARY

AgeRange: 0 to 999 Years Gender: Both

Category: Revenue Code

Limit

Limit Code	Limit Desc	Period Type	Time Period Value	Anchor Date	PA Override	Allowed units	Used Units	Balance Units
No Records Found!								

Indicators

Claim Type	Modifier	Indicator Name	Indicator Value	Start Date	End Date
R-Inpatient		PROC_NH_IND	Y-Y	01/01/1964	12/31/2999
R-Inpatient		PROC_REFER_IND	N-No	01/01/1964	12/31/2999
R-Inpatient		Prior Authorization	N-No	01/01/1964	12/31/2999
R-Inpatient		Procedure Tooth Requirement Indicator	N-TOOTH CODE NOT REQUIRED	01/01/1964	12/31/2999
R-Inpatient		QUADRANT NMBR RQURD INDCTR	N-No	01/01/1964	12/31/2999
R-Inpatient		TOOTH_SURF_CD	N-No	01/01/1964	12/31/2999
R-Inpatient		Trauma Code	N-No	01/01/1964	12/31/2999

View Page: 1 [Go](#) [Page Count](#) [SaveToXLS](#) Viewing Page: 2 [First](#) [Prev](#) [Next](#) [Last](#)

- Click Yes on the Diagnosis Code/Revenue Code covered
- The display gives details about the code and indicators
- This is where prior authorization is indicated
- Information can be verified using the Fee Schedule that can be found on the main webpage

Member Eligibility- Member File

Member ID: 0000224651 Name: CAINE, MARABEL

Benefit Plan ID	Benefit Plan Type	Provider ID	Service Type Details	Created Date	Transaction Date	Start Date	End Date
NH	FEE FOR SERVICE		Click To View Service Types	06/27/2022	06/27/2022	10/27/2022	10/27/2022

View Page: Viewing Page: 1

PATIENT PAY

Services Applicable	Patient Pay Amount	PPA Start Date	PPA End Date
No Records Found!			

Benefits Utilization

Coverage	Allowed Units	Used Units	Remaining Units	Year
Occupational Therapy	20	0	20	2022
Speech Therapy	30	0	30	2022
Physical Therapy	20	0	20	2022
Behavioral Health Visits	30	0	30	2022

- Plan is noted on this part of the file.
 - When a plan is noted, the member is eligible for Medicaid
- Benefit utilization is also displayed here

Attestation and LT101

Attestation and LT101

Attestation form



Attestation for Admission Date

THE FOLLOWING INFORMATION IS REQUIRED TO AVOID CLAIM DENIALS

Facility Name	_____	Facility NPI/ Provider Number	_____
Member Name	_____	Member ID	_____
Original Admission Date	_____	PASRR Date	_____

Indicate why the admission claim is not on file as paid by Wyoming Medicaid:

Paid by Medicare

Paid as private pay

Paid by another insurance

PASRR not completed appropriately *(please explain)*

Other *(please explain)*

In signing this document, I attest that the above information was completed as required by Wyoming Medicaid Policy, and that the information furnished is true and accurate.

Signature _____

Date _____

Printed Name _____

Mail completed form to:
Wyoming Medicaid Fiscal Agent
Attn: Claims Department
P.O. Box 547
Cheyenne, WY 82003-0547



Attestation form:

- The Attestation form can be found at:
 - [Attestation Form](#)
- This is used when Medicaid doesn't pay the admit claim

LT101- List and information

LT101 Assessment Information

Member ID Filter By

Assessment Number	Member ID	First Name	Last Name	Provider ID	Provider Name	Provider Referral Date	Assessment Date	LOC Met	Status

View Page: Viewing Page: 1

- LT101's are valid for 1 Year (365 days)
- [Gateway Login \(wyo.gov\)](http://wyo.gov)– This is the website to request LT101
- LT101's will be stored on the BMS (Provider Portal)
- Statistical information will be populated on the first screen

PASRR Level I and Screen for PASRR II

Completing a PASRR Level I and list for PASRR II

PASSR Level I- Manual Information

BEGINNING July 1, 2022, the PASRR process must be completed prior to admission of resident. This includes the PASRR Level I and if needed the PASRR Level II.

PASRR Level 1 – Pre-Admission Screening and Resident Review

- As a result of PASRR all applicants to Medicaid-certified nursing facilities must be screened for: Mental Illness (MI), Intellectual/Developmental Disability (ID/DD) or Related Condition (RC), regardless of funding and...
 - Known or suspected condition must trigger evaluation
 - To ensure appropriateness of NF placement
 - To ensure receipt of needed services
Screens for potential diagnosis of mental illness or intellectual disability
- This is found in the manual in chapter : 19.3.4.2

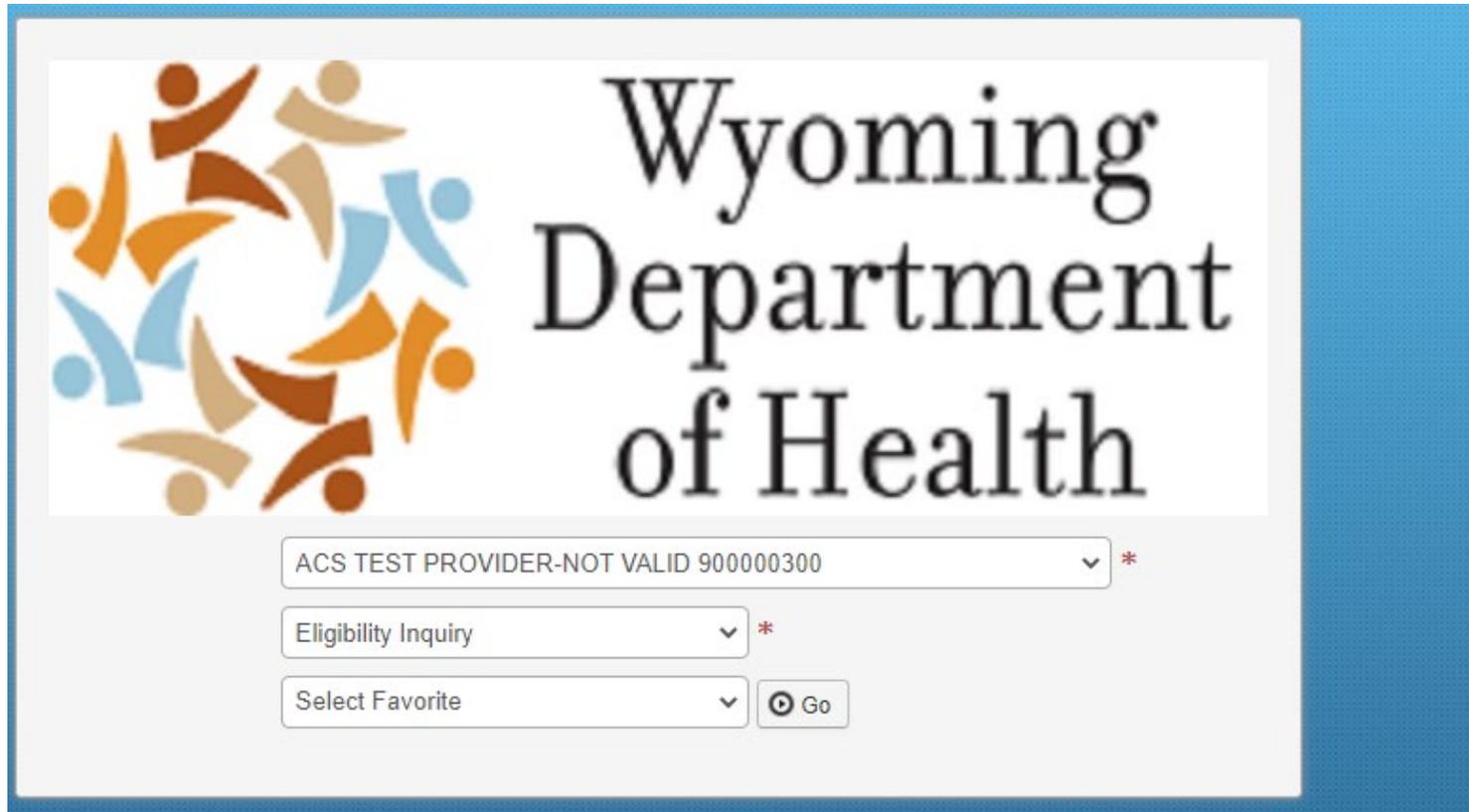
PASRR Level I -Significant Change in Condition

- A PASRR Level I Resident Review must be completed if there is a significant change in condition.
- A significant change in condition is defined as:
 - A condition that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions.
 - The decline is not considered “self- limiting”
- Impacts more than one area of the resident’s health status; and
- Requires interdisciplinary review and/or revision of the care plan.

PASRR Level I-ICD10data.com

- Diagnosis must be valid for Medicaid billing
 - [Diagnosis codes](#) will tell you which codes are good for billing
 - The diagnosis codes with the red arrow are not allowed by Medicaid.
 - In most cases the green arrows are accepted by Medicaid
- Diagnosis codes are required for a PASRR I and II.

PASRR Level I- Sign in



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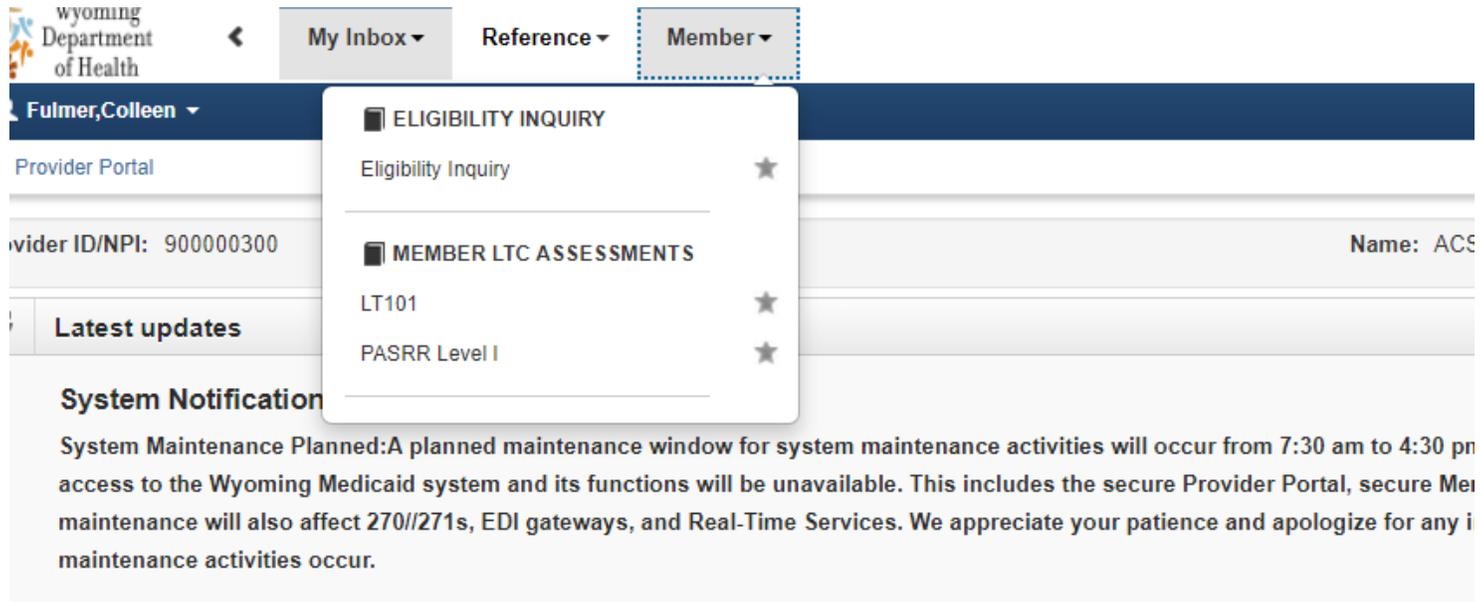
ACS TEST PROVIDER-NOT VALID 900000300 ▼ *

Eligibility Inquiry ▼ *

Select Favorite ▼

- Go to [Wyoming Medicaid HomePage](#)
- Select the appropriate domain (Provider ID)
- Select Eligibility Inquiry

PASRR Level I- Adding a PASRR Level I



- Select Member
- Select PASRR Level I
- Select “Add”

PASRR Level I- Resident Review

Close Inactivate

PASRR Level I Information

Is this PASRR a Resident Review? No Yes *

Admission PASRR - PASRR completed prior to the admission of the individual.

Resident review - PASRR completed prior to expiration of a categorical time period and the individual is going to be in the NH past the expiration or after admission when the individual undergoes a "significant change" in status and that change has material impact on their functioning as it relates to their mental illness or intellectual disability.

Member ID:	0000224651	Middle Name:		Last Name:	Caine
First Name:	Marabel	DOB:	12/01/1925	Gender:	Female
SSN:		Date of Review:	06/29/2022 *	Date of Admission:	06/29/2022 *
Payment Source:	---SELECT---	Provider ID-Name:	198803292 - Xantiwai *	Admitted from Name:	
Admit Facility NPI:	1194105684 *	City:	CITY_NAME_4754	Prior Level II:	No
State:	WYOMING	Created By:	Tearpak,Mary	Created Date:	06/29/2022

- Is this PASSR a resident review?
 - If yes, was there a significant change in condition?
 - If no, this is an admit PASRR II
- Enter all the member statistical data
- Enter the NPI of the provider
 - If correct the facility information will populate

PASRR Level I- Address for Non-Medicaid Members

☰ Address (only for Non-Medicaid Members)

Address Type: *

Start Date: 

End Date: 

Address Line 1: *

(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town: *

State/Province: *

County:

Country: *

Zip Code: * -

If the member is not Medicaid eligible at the time of the PASRR I, validate the members address

PASRR Level I- Diagnosis codes

Diagnosis Codes	
Primary Psychiatric Diagnosis:	
1:	<input type="text" value="f339"/> N-MAJOR DEPRESSIVE DISORDER RECURRENT UNS
PRI/SEC Diagnosis of OBS, Dementia, or Alzheimer's:	
1:	<input type="text" value="f0390"/> N-UNSPEC DEMENTIA WITHOUT BEHAVIORAL DISTU
PRI/SEC Diagnosis of Intellectual Disability/Developmental Disability:	
1:	<input type="text"/> <input type="text"/>
Current Medical Diagnosis:	
1:	<input type="text" value="m47816"/> N-SPONDYLOSIS W/O MYELOPATH/RADICULOPATHY
3:	<input type="text"/> <input type="text"/>
5:	<input type="text"/> <input type="text"/>
7:	<input type="text"/> <input type="text"/>
9:	<input type="text"/> <input type="text"/>

- Enter the appropriate diagnosis codes.
 - All diagnosis codes must be entered with out the “.” or decimal point
- If the diagnosis code does not populate a description, it is invalid.
 - Visit ICD10data.com for allowed diagnosis code(s)

PASRR Level I- Screening Question

☰ Screening

Mental Illness Screening (answer all questions)

1. Does this person have a psychiatric diagnosis?
 No Yes *

2. Does this person have any history of Mental Illness requiring treatment more intensive than outpatient services in the past two years?
 No Yes *

3. Is there any presenting evidence of Mental Illness including possible disturbance in orientation, affect or mood that is not attributable to dementia or other medical diagnosis list above?
 No Yes *

☰ Screening

Intellectual Disability Screening (answer all questions)

1. Does this person have a diagnosis of Intellectual Disability or Developmental Disability?
 No Yes *

2. Does this person have any history of Intellectual Disability or Developmental Disability?
 No Yes *

3. Are there cognition or behavior deficits indicating Intellectual Disability or Developmental Disability?
 No Yes *

4. Was this person referred by an agency that serves persons with Intellectual Disability and Developmental Disability, and has this person been eligible for that agency's service?
 No Yes *

- Each question must be answered yes or no as applicable for the PASRR Level I
- This is resident specific

PASRR Level I- Categorical Determination

Categorical Determination For MI or ID Individual

Answer ALL questions for any individual who may have Mental Illness (MI) or Intellectual Disability (ID). A Categorical Determination is not an exemption from PASRR; You must attach an LT101 and current history and physical to verify determination. The nursing facility must re-review this individual making sure all necessary services are being provided.

1. Does this individual have possible or probable MI or ID, does he or she have a terminal illness, verified in writing by a physician?
 No Yes *
2. Does this individual have possible or probably MI or ID, is he or she comatose, ventilator-dependent, functioning at brainstem level, have a diagnosis of COPD, severe Parkinson's Disease, Amyotrophic Lateral Sclerosis, Congestive Heart Failure, Huntington's Disease, CVA, quadriplegia, advanced multiple sclerosis, muscular dystrophy, end-stage renal disease(ESRD), severe diabetic neuropathy or refractory anemia which is so severe that the individual could not participate in the evaluation or would not benefit from specialized services?
 No Yes *
3. Does this individual have possible or probable MI or ID, does he or she have a medical condition, subsequent to discharge from acute care hospital, for which convalescent care is likely to require LESS THAN 120 days of nursing facility services?
 No Yes *
4. Does this individual have possible or probable MI or ID, does he or she require a provisional placement for respite care or due to delirium not to exceed 14 days?
 No Yes *
5. Does this individual have possible or probable MI or ID, does he or she require an emergency placement for his or her safety, not to exceed 7 days?
 No Yes *

- These questions will drive the need for a PASRR II and create the categorical determination for the PASRR Level I

PASRR Level I- Submission

Electronic Signature Statements of Understanding		
Provider Name: Tearpak, Mary		Date: 06/29/2022
1. I am the person represented by the name displayed above.		
2. I have agreed to submit the PASRR level 1 screening by electronic means.		
3. I have read the definitions and conditions incorporated into this level 1 screening instrument; and I certify that the information entered is true and correct to the best of my knowledge and is adequately documented in the applicant/resident case record.		
4. I understand that an electronic signature has the same legal effect and enforceability as a written signature.		
<input checked="" type="checkbox"/> By checking this box, I am electronically signing this PASRR level 1 screening.		
PASRR Level I Screening Summary		
Value	Decision	Additional Information
6	Categorically appropriate for convalescent care after acute hospital stay, not to exceed 120 days	Attach current LT101, current history and physical, and comprehensive drug history. An individualized Level II determination will be required on the 120th day if client stay will be extended, please plan accordingly.

- After completing the PASRR Level I, select the small box and electronically sign the PASRR Level I
- The PASRR Level I screen summary indicates whether a PASRR II or categorical determination was made.

PASRR Level I- Submission

Provider Portal > Member PASRR Level I Assessments List > Member PASRR Level I Assessment Information

Close Submit 

Add PASRR Level I

Is this PASRR a Resident Review? No Yes *

Member ID:

First Name:

SSN:

Payment Source:

Admit Facility NPI: *

State:

- When complete, click “Submit” at the top of the screen for submission
- This is retrievable from the PASSR list that members PASSRS are held in.

PASRR I- List

Level I Screening Number	Member Id	First Name	Last Name	NPI	Provider Id	Provider Name	Review Date	Level I Determination	Status
75				1598359085	206636000		02/14/2022	1-MI	Completed

- If the PASRR Level I categorical determination is a 4-8 it is time sensitive.
 - A resident review and a full PASRR Level II must be completed prior to the end of the designated time

Value, Bill Type & Patient Status Codes

Value Codes 80 and 81- Requirement

- Previously Wyoming Medicaid policy required minimal use of value codes (80 and 81)
- The use of value codes, occurrence codes and occurrence span codes as appropriate are mandatory requirements as of January 01, 2022
- 80 – Covered days and member is in facility
- 81 – Non-Covered Days when the member is out of facility

Bill Type(s)

4	Type of Bill	X	X	Enter the three (3) digit code indicating the specific type of bill. The code sequence is as follows:	
	First Digit			<u>Second Digit</u>	<u>Third Digit</u>
	1 Hospital			1 Inpatient	0 Non-payment/Zero Claim
	2 Skilled Nursing			2 ESRD	1 Admit through discharge Claim
	3 Home Health			3 Outpatient	2 Interim – 1st Claim
	7 Clinic (ESRD,FQHC,RHC, IHS or CORF)			4 Other	3 Interim – Continuing claim
	8 Special Facility (Hospital, CAH)			5 Intermediate Care Level 1	4 Interim – Last claim (thru Date is discharge date)
				6 Intermediate Care Level 2	7 Adjustment or Replacement of a Prior Claim
				7 Subacute Inpatient	8 Void of a Prior Claim
				8 Swing Bed Medicare/Medicaid	

- Bill type should accurately reflect the patient status

• Example

- Type of bill : 211
- Patient status is: 30
- Type of Bill is: Discharged
- Patient Status is :Still a patient
- The type of bill does not match patient status
 - Type of bill should be 212 or 213

Patient Status Codes

01	Discharged to home or self-care
02	Discharged/transferred to general hospital
03	Discharged/transferred to SNF
04	Discharged/transferred to an (ICF)
06	Discharged/transferred to home care
07	Left against medical advice
20	Expired
30	Still a patient

- Patient status must be on all claims
- There are other statuses, but these are the most common
- Patient status codes other than 30 (Still a patient) the BMS will automatically deduct one day

Value Code 80

Medicaid Primary Billing Examples

Example 1- Value Code 80 Covered Days – Still a patient

- NH Claim – rev code 100
- TOB 21X
- Medicaid Only
- Admit date 07/25/221
- Still a patient
- Coverage dates 05/01/22-05/31/22

The first example is a straight Medicaid claim with no other insurance.

Example 1- Value Code 80 Covered Days

CLAIM INFORMATION

CLAIM DATA

Patient Control No.: *

Medical Record No.:

Type of Bill: * (Enter 4 digits with leading zero.)

Statement Dates: From: mm dd yyyy To: mm dd yyyy
05 01 2022 * 05 31 2022 *

Admission Date/Hour: mm dd yyyy hh mm
07 25 2021 - :

Admission Type:

Admission Source: *

Discharge Hour: hh mm
:

Patient Status: *

Principal Diagnosis Code: * POA:

Diagnosis Code Category: * Auto Accident State/Province:

CONDITION INFORMATION

OCCURRENCE INFORMATION

OCCURRENCE SPAN INFORMATION

VALUE INFORMATION

1. Value Code: * Value Amount: *

For Claim information:

- Asterisk indicates data is needed for the field
- The patient control number is the member ID number for the facility
- Value codes and Date of service must match

Example 1- Service Line Information

SERVICE LINE ITEM INFORMATION			
Service Line Items			
Revenue Code:	<input type="text" value="0100"/>	*	
HCPCS Code:	<input type="text"/>		
Service Date:	<input type="text" value="05"/>	<input type="text" value="01"/>	<input type="text" value="2022"/>
	<small>mm</small>	<small>dd</small>	<small>yyyy</small>
Last Date of Service:	<input type="text" value="05"/>	<input type="text" value="31"/>	<input type="text" value="2022"/>
	<small>mm</small>	<small>dd</small>	<small>yyyy</small>
Service Units:	<input type="text" value="31"/>	*	
Total Line Charges:	<input type="text" value="\$1,000.00"/>	*	
Operating Physician ID: (If different from header):	<input type="text"/>		
Other Operating Physician ID: (If different from header):	<input type="text"/>		
Rendering Physician ID: (If different from header):	<input type="text"/>		
Referring Physician ID: (If different from header):	<input type="text"/>		
National Drug Code:	<input type="text"/>	Quantity:	<input type="text"/>
Unit:	<input type="text"/>	Unit:	<input type="text"/>
Qualifier:	<input type="text"/>	Qualifier:	<input type="text"/>
Prescription/Link No:	<input type="text"/>	Prescription/Link No:	<input type="text"/>

- Service date will match statement dates and Value Code 80
- Total line charges is your usual and customary charges
 - The cost of the facility doing business

Example 2- Value Code 80 – Date of Death

- NH Claim – rev code 100
- Type Of Bill 21X
- Medicaid Only
- Admit date 07/25/221
- Date of Death 05/15/2022
- Coverage dates 05/01/22-05/15/22

This is for a straight Medicaid claim with Date of Death.

Medicaid does not reimburse for the date of death.

The BMS automatically deducts 1 day from dates of service billed.

Example 2- Value Code 80 – Date of Death

CLAIM DATA

Patient Control No.: *

Medical Record No.:

Type of Bill: * (Enter 4 digits with leading zero.)

Statement Dates: From: * To: *

Admission Date/Hour: - :

Admission Type:

Admission Source: *

Discharge Hour: :

Patient Status: *

Principal Diagnosis Code: * POA:

Diagnosis Code Category: *

Auto Accident State/Province:

CONDITION INFORMATION

OCCURRENCE INFORMATION

1. Occurrence Code: * Occurrence Date: *

OCCURRENCE SPAN INFORMATION

VALUE INFORMATION

1. Value Code: * Value Amount: *

DELAY REASON

- Value code 80 is for the full 15
 - The Date of Death
 - Date of Death is May 15th

Examples 2- Value Code 80 – Date of Death

SERVICE LINE ITEM INFORMATION

Service Line Items

Revenue Code: *

HCPCS Code:

Service Date: mm dd yyyy

Last Date of Service: mm dd yyyy

Service Units: *

Total Line Charges: *

Operating Physician ID: (If different from header):

Other Operating Physician ID: (If different from header):

Rendering Physician ID: (If different from header):

Referring Physician ID: (If different from header):

National Drug Code: Quantity: Unit: Qualifier: Prescription/Link No:

Modifiers: 1: 2: 3: 4:

HCPCS Description:

Characters Remaining:

Non-covered Line Charges:

Type:

Type:

Type:

Type:

- Bill all days through the Date of Death
- Medicaid will not pay for Date of Death
- The provider portal will account for this and adjust accordingly

Example 3- Value Code 80 – Date of Discharge

- NH Claim – rev code 0100
- TOB 21X
- Medicaid Only
- Admit date 07/25/221
- Date of Discharge 05/10/2022
- Coverage dates 05/01/22-05/10/22

This is a straight Medicaid claim with a Date of Discharge

Example 3 – Value Code 80 – Date of Discharge

CLAIM INFORMATION

CLAIM DATA

Patient Control No.: 123456 *

Medical Record No.:

Type of Bill: 0211 * (Enter 4 digits with leading zero.)

Statement Dates: From: mm dd yyyy To: mm dd yyyy
05 01 2022 * 05 10 2022 *

Admission Date/Hour: mm dd yyyy hh mm
04 30 2022 - :

Admission Type: 3

Admission Source: 4 *

Discharge Hour: hh mm
09 : 30

Patient Status: 01 *

Principal Diagnosis Code: F39 * POA: Auto Accident State/Province:

Diagnosis Code Category: ICD-10-CM *

CONDITION INFORMATION

OCCURRENCE INFORMATION

OCCURRENCE SPAN INFORMATION

VALUE INFORMATION

1. Value Code: 80 * Value Amount: 10 *

- Value code 80 is for the full 10 days as the BMS will deduct the Date of Discharge
 - The member was a resident 10 days including date of discharge,

Example 3- Value Code 80 – Date of Discharge

SERVICE LINE ITEM INFORMATION

Service Line Items

Revenue Code: *

HCPCS Code:

Service Date: mm dd yyyy

Last Date of Service: mm dd yyyy

Service Units: *

Total Line Charges: *

Operating Physician ID: (If different from header):

Other Operating Physician ID: (If different from header):

Rendering Physician ID: (If different from header):

Referring Physician ID: (If different from header):

National Drug Code: Quantity: Unit: Qualifier: Prescription/Link No:

Modifiers: 1: 2: 3: 4:

HCPCS Description:

Characters Remaining:

Non-covered Line Charges:

Type:

Type:

Type:

Type:

- Bill all days through the Date of Discharge
- Medicaid will not pay for Date of Discharge,
- The provider portal will account for this and adjust accordingly

Value Codes 80 and 81

Medicaid Primary Billing Examples

Example 1- Value Codes 80 and 81

- NH Claim – rev code 0100
- TOB 21X
- Medicaid Only
- Admit date 07/25/2021
- Leave Dates: 08/03/2021-08/07/2022
- Coverage dates 08/01/2021-08/31/2021

This will be a straight Medicaid claim no other insurance, but leave dates for the member

Examples 1- Value Codes 80 and 81

Patient Control No.: *

Medical Record No.:

Type of Bill: * (Enter 4 digits with leading zero.)

Statement Dates: From: * To: *

Admission Date/Hour: - :

Admission Type:

Admission Source: *

Discharge Hour: :

Patient Status: *

Principal Diagnosis Code: * POA:

Diagnosis Code Category: *

Auto Accident State/Province:

VALUE INFORMATION

1. Value Code: * Value Amount: *

2. Value Code: Value Amount:

- Value codes 80 and 81 must equal the days billed

Example 1- Value Codes 80 and 81

Revenue Code:	<input type="text" value="0100"/> *				
HCPCS Code:	<input type="text"/>				
Service Date:	<input type="text" value="02"/> <small>mm</small>	<input type="text" value="01"/> <small>dd</small>	<input type="text" value="2022"/> <small>yyyy</small>	Modifiers:	1: <input type="text"/> 2: <input type="text"/> 3: <input type="text"/> 4: <input type="text"/>
Last Date of Service:	<input type="text" value="02"/> <small>mm</small>	<input type="text" value="28"/> <small>dd</small>	<input type="text" value="2022"/> <small>yyyy</small>	HCPCS Description:	<input type="text"/>
Service Units:	<input type="text" value="20"/> *				Characters Remaining: <input type="text" value="80"/>
Total Line Charges:	<input type="text" value="\$3,000.00"/> *			Non-covered Line Charges:	<input type="text"/>
Operating Physician ID: (If different from header):	<input type="text"/>			Type:	<input type="text"/>
Other Operating Physician ID: (If different from header):	<input type="text"/>			Type:	<input type="text"/>
Rendering Physician ID: (If different from header):	<input type="text"/>			Type:	<input type="text"/>
Referring Physician ID: (If different from header):	<input type="text"/>			Type:	<input type="text"/>
National Drug Code:	<input type="text"/>	Quantity:	<input type="text"/>	Unit:	<input type="text"/>
		Qualifier:	<input type="text"/>	Prescription/Link No:	<input type="text"/>

- Revenue Code 0100 signifies Room and Board days
- Total days are billed
- Claims that do not have a leave of absence bill the full date range
 - Example 08/01-08/31 vs 08/01-08/01

Example 1- Value Codes 80 and 81

Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: \$3000.00

Click on Insurance Info to enter each Line's Insurance Information.

Line No	Revenue Code	HCPCS Code	Modifiers				Dates		Units	Charges	Non covered Charges	
			1	2	3	4	Service Date	Last DOS				
1	0100						02/01/2022	02/28/2022	20	3000.00		Enter Insurance Info  

- Value code 80 equals 20
- Value code 81 equals 8
- Total charges is shown in the right-hand corner for \$3000.00

Value Code 80, 81 and 82

Medicare Billing Examples

Example 1- Value code 80, 81 and 82

- NH Claim –Rev Code 0100
- TOB 21X
- Medicaid and Medicare
- Admit date 04/01/2022
- Medicare covered dates = 10
- Coverage dates 05/01/22-05/21/22

This will be an example of Medicare billing with Medicaid

Example 1- Value code 80 and 82

CLAIM DATA

Patient Control No.: *

Medical Record No.:

Type of Bill: * (Enter 4 digits with leading zero.)

Statement Dates: From: * To: *

Admission Date/Hour: - :

Admission Type:

Admission Source: *

Discharge Hour: :

Patient Status: *

Principal Diagnosis Code: * POA:

Diagnosis Code Category: * Auto Accident State/Province:

- When billing Medicare bill the therapy (ancillary) codes as appropriate
- Therapy codes are included in the Nursing Home per diem for
 - Medicare will pay therapy charges
 - If billed on an OPPS/Professional claim, therapy codes will deny, and show as a denial on the RA

Example 1- Value code 80 and 82

SERVICE LINE ITEM INFORMATION			
Service Line Items			
Revenue Code:	<input type="text" value="0100"/>	*	
HCPCS Code:	<input type="text"/>		
Service Date:	<input type="text" value="05"/>	<input type="text" value="01"/>	<input type="text" value="2022"/>
	<small>mm</small>	<small>dd</small>	<small>yyyy</small>
Last Date of Service:	<input type="text" value="05"/>	<input type="text" value="31"/>	<input type="text" value="2022"/>
	<small>mm</small>	<small>dd</small>	<small>yyyy</small>
Service Units:	<input type="text" value="31"/>	*	
Total Line Charges:	<input type="text" value="1000.00"/>	*	
Operating Physician ID: (If different from header):	<input type="text"/>		
Other Operating Physician ID: (If different from header):	<input type="text"/>		
Rendering Physician ID: (If different from header):	<input type="text"/>		
Referring Physician ID: (If different from header):	<input type="text"/>		
National Drug Code:	<input type="text"/>	Quantity:	<input type="text"/>
Unit:	<input type="text"/>	Qualifier:	<input type="text"/>
Prescription/Link No:	<input type="text"/>		

- When billing Medicare bill the therapy (ancillary) codes as appropriate
- Therapy codes are included in the Nursing Home per diem for
 - Medicare will pay therapy charges
 - If billed on an OPPS/Professional claim, therapy codes will deny, and show as a denial on the RA

Example 2- Value codes 80, 81 and 82

- NH Claim – Rev Code 0100
- TOB 21X
- Medicaid and Medicare
- Admit date 04/01/2022
- Medicare covered dates = 10
- Leave days- 05/05/22-05/10/22
- Coverage dates 05/01/22-05/31/22

This will be an example of
Medicare billing with leave days

Example 2- Value codes 80, 81 and 82

Patient Control No.:	<input type="text" value="12345"/>	*
Medical Record No.:	<input type="text"/>	
Type of Bill:	<input type="text" value="0212"/>	*
Statement Dates:	From: <input type="text" value="02"/> <input type="text" value="01"/> <input type="text" value="2023"/>	(Enter 4 digits with leading zero.)
Admission Date/Hour:	<input type="text" value="01"/> <input type="text" value="07"/> <input type="text" value="2021"/> <input type="text"/> : <input type="text"/>	To: <input type="text" value="02"/> <input type="text" value="28"/> <input type="text" value="2023"/>
Admission Type:	<input type="text" value="3"/>	
Admission Source:	<input type="text" value="4"/>	*
Discharge Hour:	<input type="text"/> : <input type="text"/>	
Patient Status:	<input type="text" value="30"/>	*
Principal Diagnosis Code:	<input type="text" value="G9341"/>	*
Diagnosis Code Category:	<input type="text" value="ICD-10-CM"/>	*
POA:	<input type="text"/>	
Auto Accident State/Province:	<input type="text"/>	

CONDITION INFORMATION

OCCURRENCE INFORMATION

OCCURRENCE SPAN INFORMATION

VALUE INFORMATION

1.Value Code:	<input type="text" value="80"/>	*	Value Amount:	<input type="text" value="15"/>	*	<input type="button" value="+ Add Another"/>
2.Value Code:	<input type="text" value="81"/>		Value Amount:	<input type="text" value="8"/>		<input type="button" value="- Delete Row"/>
3.Value Code:	<input type="text" value="82"/>		Value Amount:	<input type="text" value="5"/>		<input type="button" value="- Delete Row"/>

There are three value codes that
Need to be billed

- 80- Covered days
- 81- Leave days
- 82 Medicare Coinsurance days

Example 2- Value codes 80, 81 and 82

Revenue Code:	<input type="text" value="0120"/> *								
HCPSC Code:	<input type="text"/>				Modifiers:	1: <input type="text"/>	2: <input type="text"/>	3: <input type="text"/>	4: <input type="text"/>
Service Date:	<input type="text" value="02"/>	<input type="text" value="01"/>	<input type="text" value="2023"/>		HCPSC Description:	<input type="text"/>			
Last Date of Service:	<input type="text" value="02"/>	<input type="text" value="28"/>	<input type="text" value="2023"/>						Characters Remaining: <input type="text" value="80"/>
Service Units:	<input type="text" value="20"/> *								
Total Line Charges:	<input type="text" value="\$3,000.00"/> *				Non-covered Line Charges:	<input type="text"/>			
Operating Physician ID: (If different from header):	<input type="text"/>				Type:	<input type="text"/>			
Other Operating Physician ID: (If different from header):	<input type="text"/>				Type:	<input type="text"/>			
Rendering Physician ID: (If different from header):	<input type="text"/>				Type:	<input type="text"/>			
Referring Physician ID: (If different from header):	<input type="text"/>				Type:	<input type="text"/>			
National Drug Code:	<input type="text"/>	Quantity:	<input type="text"/>	Unit:	<input type="text"/>	Qualifier:	<input type="text"/>	Prescription/Link No:	<input type="text"/>

- This line is your room and board revenue code 0120 (only if billing Medicare!)
- The total in Value code 80 is 15 days covered, and the 10 days of Medicare Covered value code 81, plus the 5 days of leave with value code 82
- This equals 28 days billed

Top 4 Claim Denials with Resolution

Edits, CARC, RARC and Resolution

Top 4 Denials - Section Review

In this section we will discuss:

- Top 4 denial reasons on Nursing Home claims
- CARC and RARC
- Medicaid Edits and descriptions
- Resolution

Top Denial-Error Code 7059

Top Denial

- Error Code 7059: Admission claim not on file
- CARC 16
 - Claim service lacks information
- RARC N221
 - Missing Admitting History and Physical Report
- Verify the admit date on the claim to NF records
 - If incorrect resubmit with correct date
 - If correct ask the following questions:
 - Who paid the admit claim?
 - If not, Medicaid complete an attestation form.
 - If Medicaid paid verify the dates match billed vs attestation
 - Is there an attestation on file with the admit date on the claim?
 - If no, complete the form, allow time to be added, then rebill with the correct admit date

Third Top Denial-Error Code 1225

- Error Code-1225
- CARC 18
 - Exact duplicate of claim
- RARC N522
 - Duplicate of claim processed
- Void or adjust the paid claim in history if the claim did not pay correctly
 - If a void is completed, rebill the claim for payment
 - If completing a void, billing before the next billing cycle will help negate confusion on payment vs take back credits on the RA

Second Top Denial- Error Code-7053

- Error Code- 7053 Invalid Rev code at the line
- This will post when these codes are wrapped into the nursing home per diem
- CARC 16
 - Claim lack information or has submission billing errors
- RARC M50
 - Missing Incomplete/invalid revenue codes
- The following revenue codes will deny:
 - 0022, 0183, 0250,0421,0431,0441,0500
 - These are ancillary codes and paid in the Nursing Home per diem
 - These codes are paid by Medicare
 - Bill as appropriate for Medicare, but expect denials on these codes
 - Revenue Code 0120 should pay, but will be at \$0.00
 - Medicare typically pays more than Medicaid on Nursing Home Cross over claims

Fourth Top Denial- Error Code 1110

5th most common Denial:

- Diagnosis code not active
- CARC 167
 - This diagnosis code is not covered
- No RARC
- Is your diagnosis code active after searching?
 - If the diagnosis codes isn't valid, find an equitable diagnosis and rebill claim
 - If the diagnosis code is valid, reach out to provider services. 1-866-996-6223 or wyprovideroutreach@cns-inc.com

Nursing Home Claim Submission

Straight Medicaid with no TPL

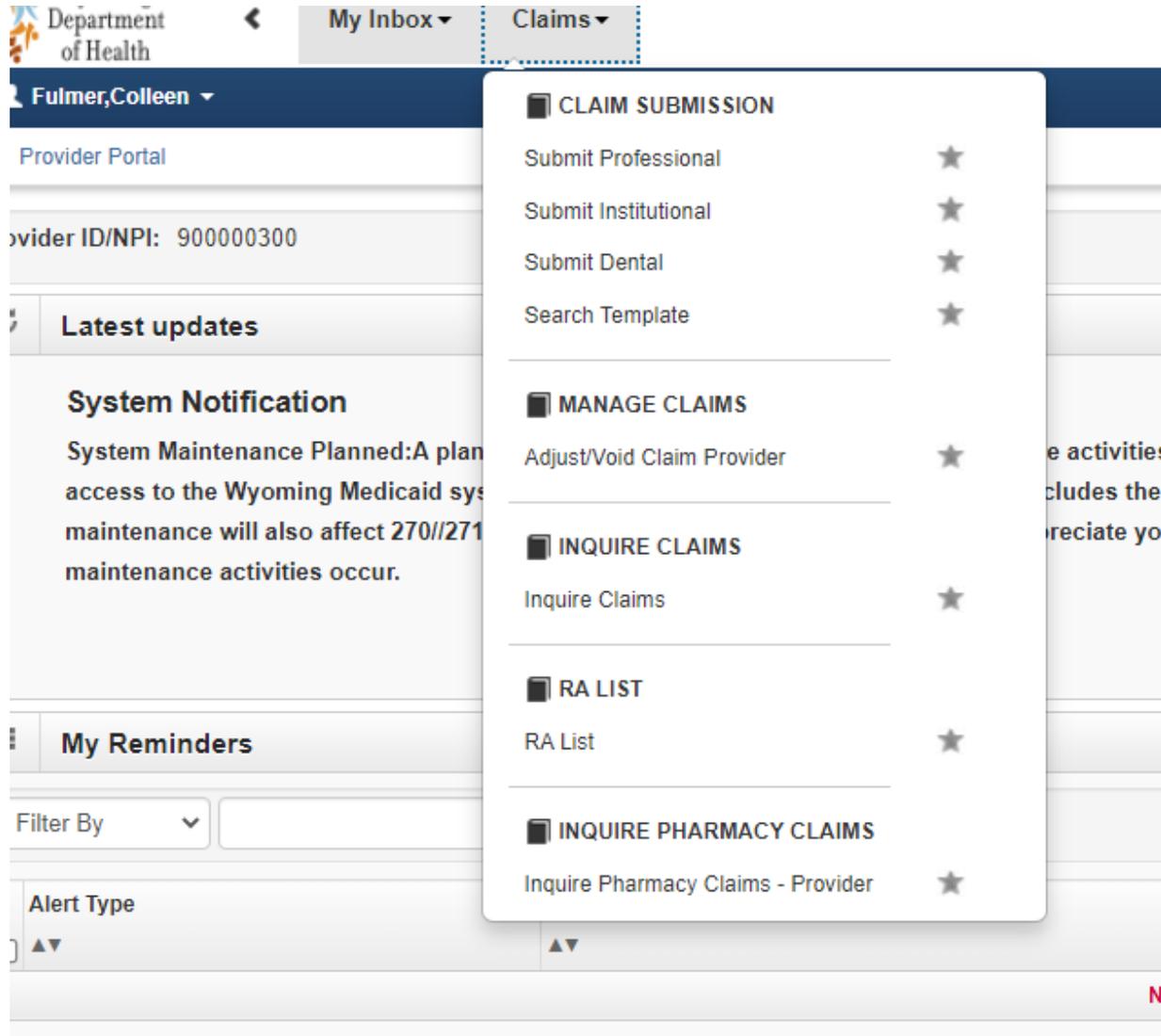
Claim Submission-Signing on



The screenshot shows the Wyoming Department of Health claim submission interface. At the top left is the department's logo, which consists of stylized human figures in blue and orange. To the right of the logo, the text "Wyoming Department of Health" is displayed in a serif font. Below the logo and text are three dropdown menus and a "Go" button. The first dropdown menu is labeled "ACS TEST PROVIDER-NOT VALID 900000300" and has a red asterisk to its right. The second dropdown menu is labeled "Prior Authorization Access" and also has a red asterisk to its right. The third dropdown menu is labeled "Select Favorite" and has a red asterisk to its right. To the right of the "Select Favorite" dropdown menu is a "Go" button with a circular arrow icon.

- After sign on:
 - Select your Domain
 - Select claims access
 - Click GO

Claims Submission- Selecting Claim



- Go to claims
- Submit Institutional

Claim Submission- Provider Information

Basic Claim Info

Provider | Beneficiary | Claim | Service Line

PROVIDER INFORMATION

BILLING PROVIDER INFORMATION

Provider ID: * Type: * Taxonomy Code: *

Address Line 1: *
(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

State/Province: *

City/Town: *

Country: *

County:

Zip Code: * -

Kilahsoo

ATTENDING PROVIDER INFORMATION

Provider ID: * Type: * Taxonomy Code:

- Basic claim info:
 - Enter the taxonomy code, all capital letters must be used on taxonomies
 - Enter the Attending Provider Information
 - The taxonomy for the attending provider is required for a one-to-one match

Claim Submission- Beneficiary Information

BENEFICIARY

Beneficiary ID: *

Last Name: * First Name: * Middle Initials: Suffix:

Date of Birth: mm dd yyyy * Gender: *

- Enter the Beneficiary ID
- All other statistical data will populate when the Medicaid number is valid.

Claim Information

CLAIM DATA

Patient Control No.: *

Medical Record No.:

Type of Bill: * (Enter 4 digits with leading zero.)

Statement Dates: From: * To: *

Admission Date/Hour: - :

Admission Type:

Admission Source: *

Discharge Hour: :

Patient Status: *

Principal Diagnosis Code: * POA:

Auto Accident State/Province:

Diagnosis Code Category: *

- Patient control number is the facility ID for the member
- To and from date will be the span date for services
- Admission date must match attestation if one is on file

Claim Information

CONDITION INFORMATION

OCCURRENCE INFORMATION

OCCURRENCE SPAN INFORMATION

VALUE INFORMATION

1.Value Code:	<input type="text" value="80"/> *	Value Amount:	<input type="text" value="26"/> *	<input type="button" value="+ Add Another"/>
2.Value Code:	<input type="text" value="81"/>	Value Amount:	<input type="text" value="5"/>	<input type="button" value="- Delete Row"/>

- Value codes 80/81 must be used in billing
 - Value Code 81 is only required when there is a leave of absence
- Value codes help identify time spans and the location of the member, which is a factor in payment

Claim Submission-Service Line-Item Information

SERVICE LINE ITEM INFORMATION

Service Line Items

Revenue Code: *

HCPCS Code:

Service Date: mm dd yyyy

Last Date of Service: mm dd yyyy

Service Units: *

Total Line Charges: *

Operating Physician ID: (If different from header):

Other Operating Physician ID: (If different from header):

Rendering Physician ID: (If different from header):

Referring Physician ID: (If different from header):

National Drug Code: Quantity: Unit: Qualifier: Prescription/Link No:

Modifiers: 1: 2: 3: 4:

HCPCS Description:

Characters Remaining:

Non-covered Line Charges:

Type:

Type:

Type:

Type:

- Enter required information for claim submission. Revenue code for Room and Board is required
 - Enter only one line of room and board
 - Revenue Code 0100 for Medicaid
 - Revenue Code 0120 for Medicare claims
- Add Service Line Item

Claim Submission- Address Validation

PROVIDER INFORMATION

BILLING PROVIDER INFORMATION

Provider ID: * Type: * Taxonomy Code: *

Address Line 1: *
(Enter Street Address or PO Box Only)

Address Line 3:

State/Province: *

Country: *

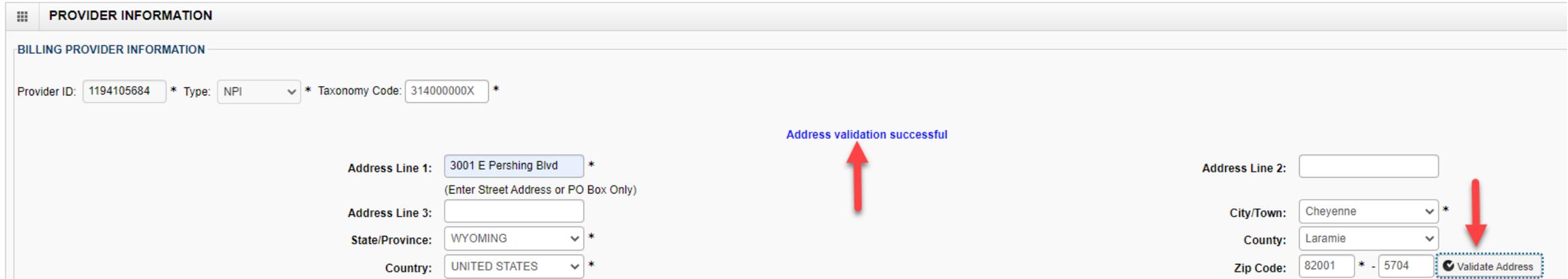
Address Line 2:

City/Town: *

County: *

Zip Code: * - *

Address validation successful



- When date entry is complete validate address and click “Submit Claim” at the top of the screen
- An additional box will pop up, if pop up blocker allows, with claim information and option to attach documentation

Reading Error Codes

Error Codes on Claims

Reading Error Code- Choosing the claim

<input type="checkbox"/>	TCN ▲▼	From Date ▲▼	To Date ▲▼	Submitted Charges ▲▼	Claim Status ▲▼
<input type="checkbox"/>	31212997000035000	08/21/2021	08/31/2021	\$3,955.71	Denied
<input type="checkbox"/>	32126000089000001	08/01/2021	08/31/2021	\$8,362.87	Denied
<input type="checkbox"/>	31212997000017000	08/11/2021	08/20/2021	\$3,596.10	Denied

- Find the claim in question by doing a claims inquiry
- Click the blue hyper link to open the claim
- A quick reference guide can be found on the Wyoming Medicaid web page listed as
 - [Claim Inquiry with Error Reason and Remark Codes](#)

Reading Error Code- Error code display

TCN	Error Code	Error Description	Reason Code	Remark Code
31212997000017000	1122	CLAIM DATA NOT MATCHING PA	15 - The authorization number is missing, invalid, or does not apply to the billed services or provider.	N54 - Claim information is inconsistent with pre-certified/authorized services.
31212997000017000	7125	LT101 CODE INVALID FOR NURSING FACILITY ADMIT	96 - Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86 - Service denied because payment already made for similar procedure within set time frame.

View Page: 1 Go Page Count SaveToXLS Viewing Page: 1 First Prev Next Last

- Click the down arrow at the top of the screen
- This will populate the error codes for claim trouble shooting
 - Paid, Denied and Pay and Report code will show
 - Suspended codes will not
- CARC and RARC will still show
- These codes will appear on the corresponding RA (Remittance Advice)

Adjustments

Adjustments for Billing

Adjustments- Signing on



Wyoming
Department
of Health

NURSING HOME-1

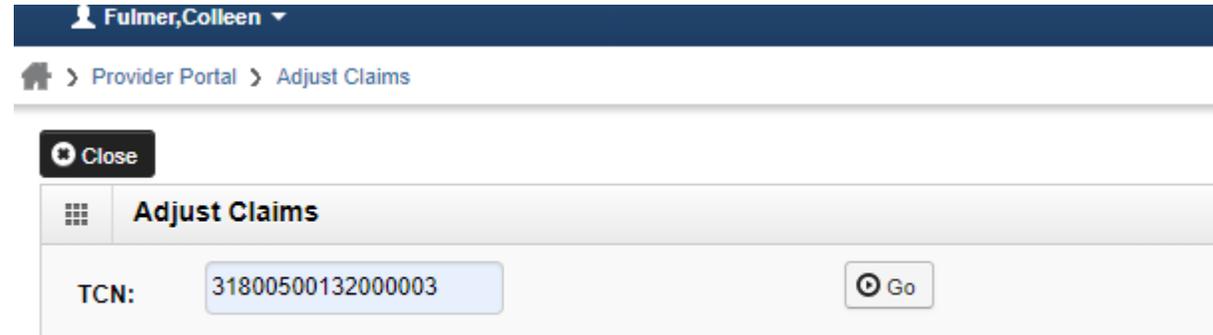
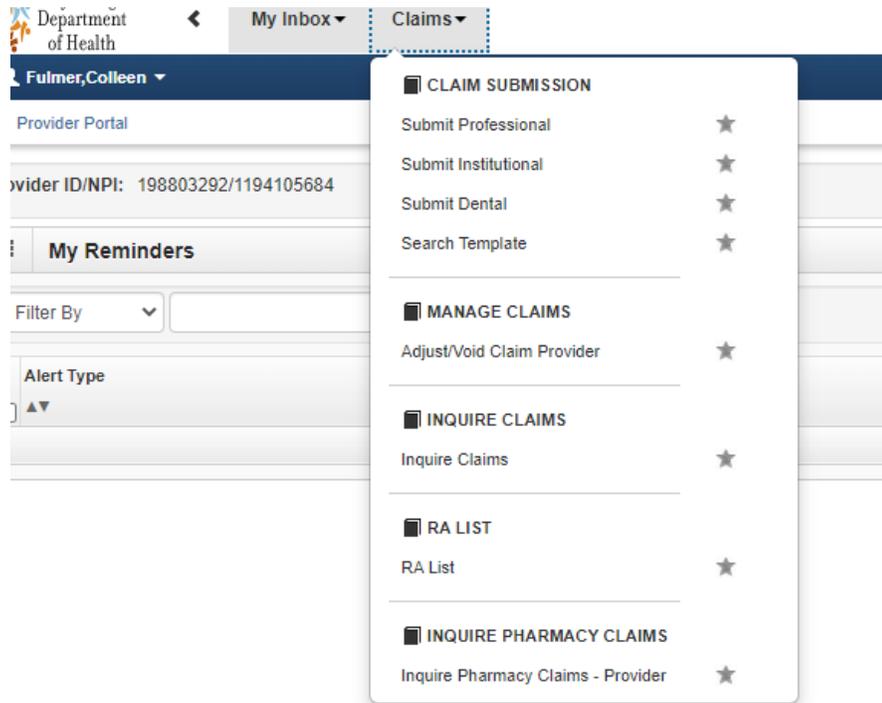
Claims Access

Select Favorite

Go

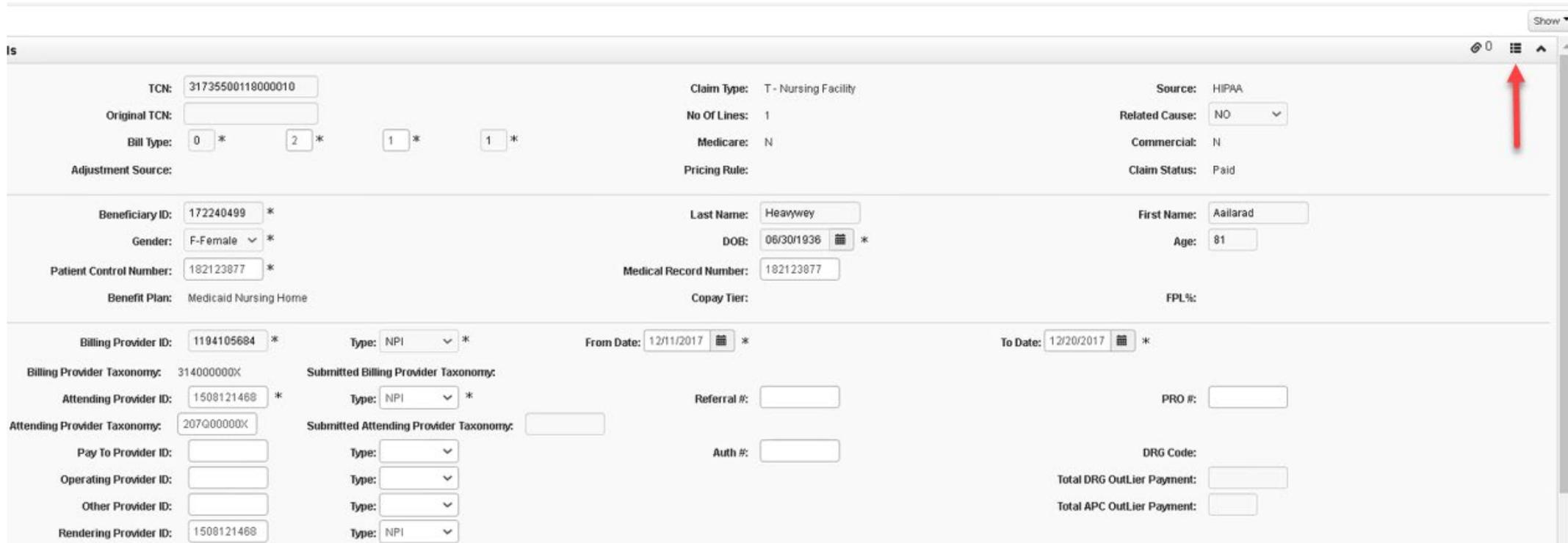
- Select the domain
- Select “Claims Access”

Adjustment-Claim Provider



- Select Adjust/Void Claim Provider
- Enter TCN to be adjusted

Adjustment- Line of the adjustment screen



The screenshot shows a web-based adjustment screen with a top navigation bar containing a 'Show' dropdown, a search icon, a list icon, and a refresh icon. A red arrow points to the list icon. The main content area is divided into several sections:

- TCN:** 31735500118000010
- Original TCN:** [Empty]
- Bill Type:** 0 * 2 * 1 * 1 *
- Adjustment Source:** [Empty]
- Claim Type:** T - Nursing Facility
- No Of Lines:** 1
- Medicare:** N
- Pricing Rule:** [Empty]
- Source:** HIPAA
- Related Cause:** NO
- Commercial:** N
- Claim Status:** Paid

Beneficiary Information:

- Beneficiary ID:** 172240499 *
- Gender:** F-Female *
- Patient Control Number:** 182123877 *
- Benefit Plan:** Medicaid Nursing Home
- Last Name:** Heavywey
- DOB:** 06/30/1936 *
- Medical Record Number:** 182123877
- First Name:** Aailarad
- Age:** 81
- Copay Tier:** [Empty]
- FPL%:** [Empty]

Provider and Date Information:

- Billing Provider ID:** 1194105684 * **Type:** NPI * **From Date:** 12/11/2017 * **To Date:** 12/20/2017 *
- Billing Provider Taxonomy:** 314000000X **Submitted Billing Provider Taxonomy:** [Empty]
- Attending Provider ID:** 1508121468 * **Type:** NPI * **Referral #:** [Empty]
- Attending Provider Taxonomy:** 207Q00000X **Submitted Attending Provider Taxonomy:** [Empty]
- Pay To Provider ID:** [Empty] **Type:** [Empty]
- Operating Provider ID:** [Empty] **Type:** [Empty]
- Other Provider ID:** [Empty] **Type:** [Empty]
- Rendering Provider ID:** 1508121468 **Type:** NPI
- Auth #:** [Empty]
- DRG Code:** [Empty]
- Total DRG OutLier Payment:** [Empty]
- Total APC OutLier Payment:** [Empty]

Go to the line level icon on the top right of the screen.
This is where the adjustment will start

Adjustment- Line Level Selection

Header TCN: 31735500118000010
Beneficiary ID: 172240499 Name: Heavywey, Aailarad

Service Lines

Filter By [] And Filter By [] [Go] Save Filters My Filters

TCN	Revenue Code	Procedure Code	Modifiers	Dental Attribute	From Date	To Date	Units	Submitted Charges	Approved Amount	Claim Status
<input type="checkbox"/> 31735500118000010001	0100				12/11/2017	12/20/2017	10	\$1,906.40	\$1,906.40	Paid

View Page: 1 Go Page Count SaveToXLS Viewing Page: 1 First Prev Next Last

- Select the line that needs to be adjusted
- If there is more than one line, all lines can be adjusted on the same adjustment claim

Adjustment- Line Level view

Header TCN: 31735500118000010
Line TCN: 31735500118000010001
Beneficiary ID: 172240499 Name: Heavywey,Aalarad

Service Line Detail

TCN: 31735500118000010001
Adjustment Source: Inpatient Per Diem
Pricing Rule: Inpatient Per Diem
Claim Type: T - Nursing Facility
Bill Type: 0 * 2 * 1 * 1 *
Source: HIPAA
Claim Status: Paid

Beneficiary ID: 172240499 Last Name: Heavywey First Name: Aalarad
Gender: Female DOB: 06/30/1936 Age: 81
Benefit Plan: Medicaid Nursing Home Copay Tier: FPL%:

Operating Provider ID: Type:
Other Operating Provider ID: Type:
Rendering Provider ID: 747622932 Type: Provider ID
Referring Provider ID: Type:
Auth #: PRO#: Referral #:
Service From Date: 12/11/2017 Service To Date: 12/20/2017

Procedure Code: Modifiers: 1: 2: 3: 4:
Submitted Procedure Code: Submitted Modifiers: 1: 2: 3: 4:
Revenue Code: 0100 * Total APC Outlier Payment:
Manual Units: Billed Units: 10 *
Manual Price: \$1,906.40 Paid Units: 10
Non-covered Line Charges: Rate: APC Code:
APC Status:

Submitted Charges: \$1,906.40 * Billed Amount: Approved Amount: \$1,906.40
Medicare Paid: Medicare Co-insurance: Medicare Deductible:
Other Insurance: Other Insurance Co-Pay: Other Insurance Deductible:

Previous Next Save Cancel

- Any box that is white can be adjusted
- Make the adjustment and click “Save” at the bottom of the screen

Adjustment- Header level

TCN:

Original TCN:

Submitted Charges: <input type="text" value=""/> *	Billed Amount: <input type="text" value=""/>	Approved Amount: <input type="text" value="\$2,097.04"/>
Medicare Paid: <input type="text" value=""/>	Medicare Co-Insurance: <input type="text" value=""/>	Medicare Deductible: <input type="text" value=""/>
Other Insurance: <input type="text" value=""/>	Other Insurance Co-Insurance/CoPay: <input type="text" value=""/>	Other Insurance Deductible: <input type="text" value=""/>
Warrant/EFT Number: <input type="text" value=""/>	RA Number: <input type="text" value="211384892"/>	Paid Date: <input type="text" value="2018-01-10"/>

- TCN will change after making an adjustment
- Once the adjustment is done click Save and Adjust
- A box will populate. Select PIA and type a comment
- Select OK to complete the adjustment

Course Wrap

These topics were covered in the power point:

- Prior Authorization Look up
- Member Eligibility
- Attestation and LT101
- PASRR Information and PASRR I submission
- Value Codes
- Billing Examples
- Top 5 common denials and how to resolve
- How to bill a straight claim
- Error Codes
- Adjustments



Wyoming
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Thank you

Claim Submission